Maine Department of Health and Human Services (DHHS) & Guidehouse

Rate Reform Studies of Long-Term Care Services Under MaineCare

Rates Workgroup Meeting #1

March 13, 2023

Agenda

- Why Are We Here: 5 Minutes
- Our Understanding of the Current State: 5 Minutes
- Approach to Developing New Rates: 5 Minutes
- Approach to Developing Trend: 5 Minutes
- Potential Options for Risk Adjustment: 5 Minutes
- Open Discussion: 30 Minutes
- Workgroup Meeting Schedule: 5 Minutes

Why Are We Here

- The Department has engaged Guidehouse to help it **reevaluate** its **reimbursement model**, and **rate methodologies** for Nursing Facilities (NFs) and Residential Care Facilities (RCFs - PNMIC LIV).
- DHHS and Guidehouse would like your help and input on the following:
  - Understand how different payment models may affect providers and residents.
  - Understand programmatic, reimbursement, quality, and fiscal goals.
  - Provide feedback on rate setting methodology options.
  - Determine what casemix risk adjustment options DHHS should consider.

✓ **Workgroup Goal:** *Advise on rate and acuity methodology options that Guidehouse will incorporate into a proposal to DHHS for rate setting.*

Our Understanding of the Current State

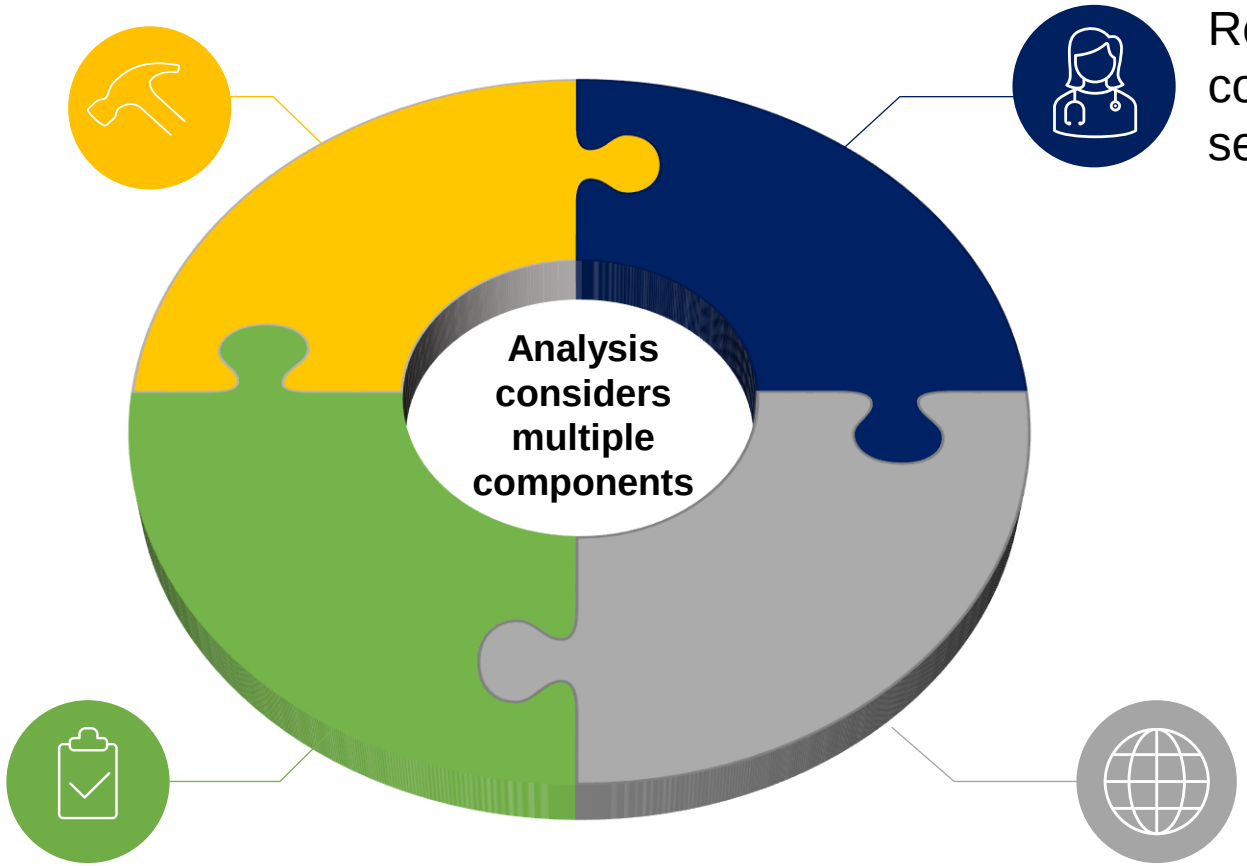
- The current NF methodology is based on cost settlement with specific caps on different rate components:
  - Rate has three components: direct, routine, and fixed.
  - Direct and routine are capped at the lessor of actual costs of the provider or the 110% median.
  - Per Part AAAA, rates must support direct care wages of at least 125% of the state minimum wage.
  - There are additional small add-ons that have been added over the years.
  - Currently rebase every two years and give inflation on the non-rebasing year.
- The current RCF (PNMIC LIV) methodology is based on per diems for direct care and cost settlement for routine and personal care services.
  - RCFs groups receive same base per diem and an average acuity adjustment.
  - Peer groups are freestanding facilities: <= 15 beds, non-freestanding <25 beds, non-freestanding >+25 beds, Alzheimer's.
  - Direct care rate was set in the 1990s and do not currently get rebased but does account for annual inflation.
  - Part AAAA 125% of the state minimum wage also applies.

Approach to Developing New Rates

- Move from a cost settlement methodology to reimbursement based fully or in part on prospective payments.
- Keep what works, update what does not.
- Create a rate methodology that incentivizes high quality care.
- Prioritize performance measures that promote quality service provision, resident health outcomes, equity, and/or experience of care.
- Incorporate acuity measures that capture the range of need associated with caring for all residents.
- Explore Value Base Payments (VBP) Alternate Payment Methodologies (APM) Models.

Approach to Developing New Rates - Con't
Building Blocks of NFs and RCFs Rate Setting

- Cost
- Location
- # of beds
- Occupancy
- Inflation



Recognizes allowable costs for covered services

Consideration of resident's specific needs (acuity level, ADL support, etc.)

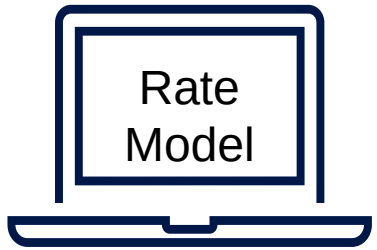
Assumptions can be derived from state, national, or industry standard data

Source of Design: Includes NFs and RCFs industries best practice rate methodologies, DHHS needs, and stakeholder input to determine the best path forward.

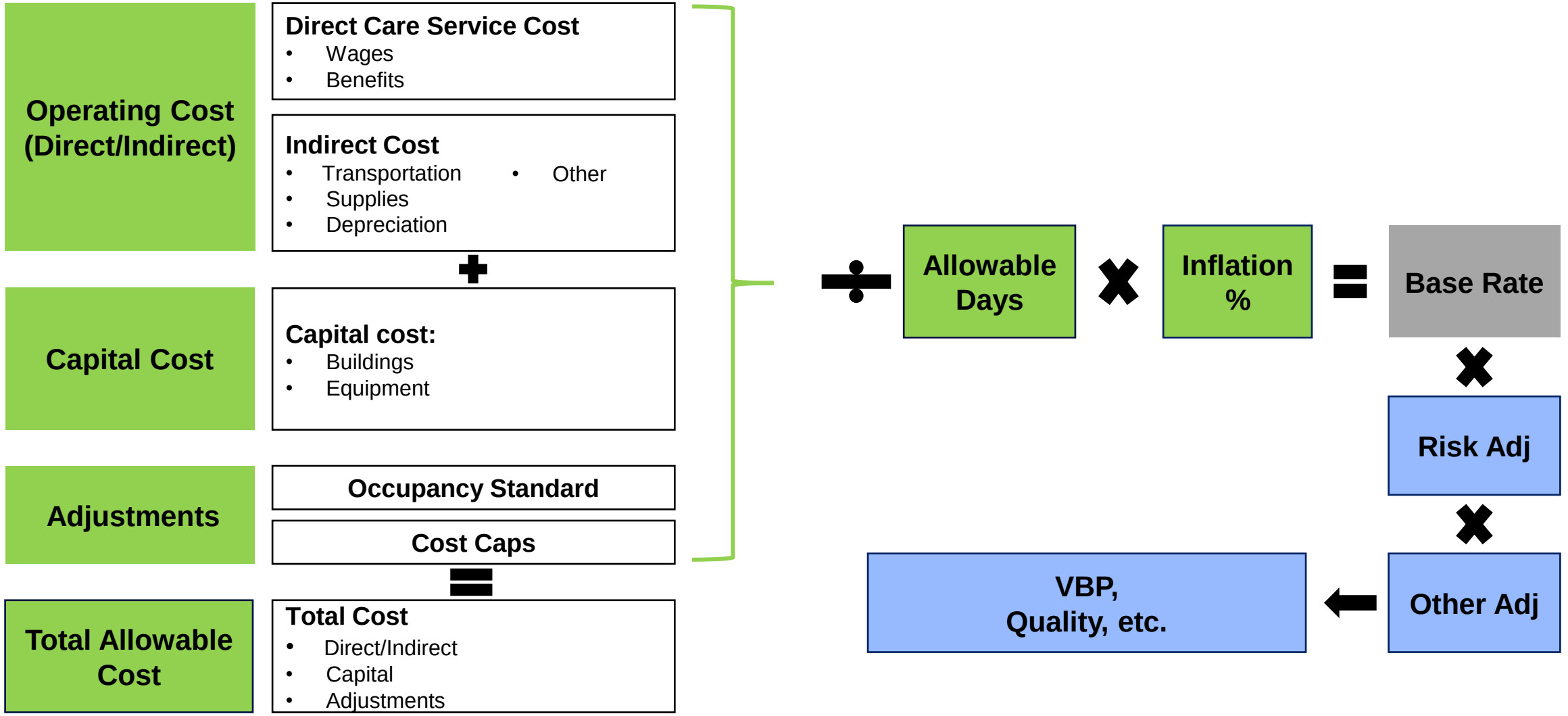
Approach to Developing New Rates - Con't

Data Sources for Rate Studies May Include

- CES Survey Data
- Wage & Inflation Data
- MMIS Claims Data
- MDS, Census, Acuity, and Occupancy Data
- Other Data (as needed)
- Other State Benchmarks
- (in)Sight HealthTM
- Nursing Facility State Plan
- CMS & State Cost Reports



Approach to Developing New Rates - Con't
Overview of General Rate Build-Up Approach



Approach to Developing Trend

- Trends will be developed using historical Maine and national data to project utilization costs from the midpoint of base data period to midpoint of contract period.
- Each facility will be trended from their respective year-end through the midpoint of the rate year for which the rates are intended.
- Cost report expenditure data will be segmented into direct, indirect, and capital costs with each cost component trended separately.
- Each component will be reviewed based on actual observed trends and projected trends.
- Separate trends will be developed for NFs and RCFs.
- Trends may be adjusted to account for assumptions for occupancy, quality, and other factors based on the rate methodology chosen.

Potential Options for Risk Adjustment

Options for Risk Adjustment:

- **3M Clinical Risk Groups & Functional Status Groups**
- Data: Claims, functional status data

- **Patient Driven Payment Model**
- Data: RUGs

- **Other**

Group Discussion Etiquette

DHHS asks that work group members limit sharing information from work group meetings outside of the group

Raise Hand

Use the raise hand feature to hold your place in “line” to speak in activities where there is a lot of discussion

Mute

Use the mute feature to avoid echoes and background noise when you are not speaking

Video

Keep your camera on during the discussion

Chat Box

Use the chat box feature to send messages to the group for all to see

SESSION EXPECTATIONS

- **Participation** is the ultimate key to a successful discussion today
- **Respect** each other’s ideas and opinions
- **Add** items to parking lot that might take over the flow.
- Make the most of the time you have **together**
- Don’t **focus** on wordsmithing. We’ll perfect and validate language following the discussion

Open Discussion:
Alternate Payment Methodologies

30 minutes

As we consider alternate payment methodologies:

1. Are there **rate payment issues** or current considerations you wish to share with the study team?
2. What current rate components do you think are **most valuable** to study?
3. Are there **gaps** in existing program design to highlight for the study team?

As we consider alternate payment methodologies:

1. Are there **rate payment issues** or current considerations you wish to share with the study team? (Workgroup questions/comments provided in the chat box)

10 minutes

1 Capital reimbursement is retrospective which is a strain on cash flow.	2 Rates are insufficient to cover costs of providing care. LTC providers experience year over year shortfalls.	3 Any ideas how the initial rates will be evaluated in the future to ensure the goals are met on a long-term basis?	4 Rules regarding lessor/lessee arrangements and allowable costs are operationally prohibitive in today's environment.	5 I didn't see any mention of financial incentives for anyone to get into the business. Decades ago we were paid an annual owner's equity payment of 10% for whatever the owner had put into the business.	6 Direct care rates are not sufficient to cover current demands of direct care workers and contract rates.
7 The peer groups need re-alignment.	8 Rates of pay don't align with the complexity of the work they do. Also ratios of staff depending on complexity of acuity should not be standard.	9 Rate increases aren't always realized because adjustment factors negate them.	10 The outline of the possibilities for rate setting seems at first glance to add complexity?	11 The lag in real world costs versus facility reimbursement is unsustainable. South Dakota currently has a proposal to reimburse facilities at 100% of cost. We should do the same.	12 Ensuring review of Northeastern data vs. national data.
13 I have seen the new model concept and do not have any major concerns overall but the issue of caps applied and how they will be calculated is critical. Can you provide some back drop as to what the group is thinking on caps?	14 Unforeseen and uncontrollable costs borne by the nursing home should be reclassified to the Capital Cost Center, or other CC therefore renamed, to allow for "pass-through" reimbursement rather than subjected to a cost cap.	15 The current system doesn't appropriately reimburse for direct care needs of dementia residents.	16 Facilities are old and in need of updates. The current system does not support this.	17 Rates providing a positive operating margin (beyond just covering reasonable cost) will be important to sustain access to capital and allow for re-investment in upgrades and replacements.	18 Hard to stay under cap in routine and Direct care is getting challenging too. Reimbursement is not high enough for dementia care at the RCF level. Employee wages are increasing rapidly.

As we consider alternate payment methodologies:

1. Are there **rate payment issues** or current considerations you wish to share with the study team? (Workgroup questions/comments provided in the chat box) Con't

10 minutes

1 Grocery stores are paid their full costs when they sell to food stamp customers as are heating oil dealers that sell to LIHEAP. Why is it that Long Term Care is forbidden to earn a profit on rendering care to state aided patients?	2 Providers are disincentivized to operate below medians.	3 The traditional thinking that urban facilities should be reimbursed at a higher rate is obsolete. Staffing costs in rural areas are in fact higher due to remote location and lack of housing.	4 Eligibility determination can be slow and often behind, appreciate this isn't rate, but it does delay cash flow.	5 Administrative allocation is not sufficient and needs to better align with the level of the work.	6 I agree that the aging of campuses are becoming an incredible issue as updates to infrastructure (Physical building and technology).
7 Need evaluation of what is considered fixed costs.	8 The PNMI reimbursement system was designed to maximize federal match --- not necessarily based on logic or a planned approach.	9 Rates should consider regional cost differences. For example - take into consideration regional and local worker shortage and it's impact on wages/benefits & cost of agency.	10 The current system doesn't incentivize cost management/control.	11	12
13	14	15	16	17	18

As we consider alternate payment methodologies:

2. What current rate components do you think are most valuable to study? (Workgroup questions/comments provided in the chat box)

10 minutes

1
Capital costs need to be evaluated as the costs increase the ability to maintain aging facilities is a challenge.

2
Suggest there needs to be a holistic review of all components. One on its own will not adequately address the issues.

3
Regulations continue to increase without rate components to align with "new" expenses.

4
I don't think a particular component is as important as Inflation adjustment, cap calculations, and frequency of rebasing.

5
PNMI administrator reimbursement is far below market.

6
The most variable component in our facilities is the cost of clinical care. Please ensure careful study here.

7
All of them! They are all inadequate. The fixed cost needs to include a lot more items, actually, everything should be a fixed cost. If we will not be paid any upside (profit) then we shouldn't suffer any downsides.

8
Wages and benefits, utilities. Cost of dementia care.

9
Ensure rate components maximize Federal matching funds. Also find new and better ways to fund the cost that education facilities provide to train new CNAs and sponsor students through nursing programs.

10
Direct costs are escalating rapidly. Wages are climbing, particularly with agency staffing expenses.

11
The Labor and benefit cost component is by far the most important.

12
Labor costs are priority #1 due to the pressures to be able to support the overall care and operations of the facility. It is not just about nursing/direct care anymore, it is about ALL labor. All ancillary depts are just as important to be able to operate and their needs to be a mechanism to get interim funding as the market is moving faster than reimbursement thank you.

13
Vehicles and transportation for residents is assumed and like all other costs are increasing with no mechanism to align with increased cost

14
Perhaps beyond scope of this work-plan but somehow controlling cost of agency costs without facilities enduring the penalty of the higher costs.

15
It's all about labor as everyone is saying. Also, I will say that the 1/1/25 is too far in advance. We will have additional closures in the interim due to mounting deficits. This will further devastate rural communities in which the SNF's/PNMI's are the largest employers in many cases.

16
Which particular component is the most critical is not as important as an Inflation adjustment that is appropriate and timely, cap calculations, and frequency of rebasing.

17
Impact that a home's environment has on the wellbeing of those utilizing the service. How do we improve the expected quality of care as more of the reimbursements for care, staffing, and capital shrinks or lags?

18
We have many "limits" or "caps" within limits, which provides for unnecessary operating burden on facilities.

As we consider alternate payment methodologies:

3. Are there **gaps** in existing program design to highlight for the study team? (Workgroup questions/comments provided in the chat box)

10 minutes

1 Glen and David said it all. We're even paying hotel costs for Travelers at $2,000 - $4,000 a month.	2 Yes, there are no programs to fund training new clinical workers.	3 Reimbursement for dementia and behavioral needs isn't adequately addressed in current direct care payment.	4 Consulting services if they are to remain need to be part of the rate.	5 Question 3, yes, already mentioned the need for financial incentives for anyone to get into this business. If all a person can do is break even, then why do it at all?	6 Inflation adj are too low, and not timely, and the caps are too low.
7 Need to figure out a more nimble way to adjust rates to account for inflation.	8 Utility costs are increasing faster than inflation and regardless of contracting where we are not going unreimbursed.	9 Inflation is not cutting it and comes too late.	10 No current program that ensures rates quickly fund operating shortfalls. We resort to working through legislature because no better avenue.	11 Current system not nimble enough to address changes in operations timely	12 Keeping up with minimum wage increases and wage compression.
13 The FFS Medicaid payments are paid in arrears and only cover program reimbursable expense. The PHE has shown the critical nature of cash flow.	14 Agency usage and costs are the primary cause of low occupancy and hospital backups and lack of availability.	15 No system can be nimble enough to react to the current economic climate. Therefore, any traditional rate structure will always be lower than actual costs. This is why I believe a 100% of cost reimbursement structure is necessary.	16 The PNMI program is the best deal going for the State. Very little General Fund money to run and rates are about half that of nursing facility services.	17 We have tried previously to get consideration for bad debt due to death prior to completion of the application.	18 Also keep in mind that banks have essentially stopped lending to facilities due to negative NOI and failing DSCR covenants so there is almost no additional access to capital at this point.

As we consider alternate payment methodologies:

3. Are there **gaps** in existing program design to highlight for the study team? (Workgroup questions/comments provided in the chat box) Con't

10 minutes

1 The Capital Cost component should be redesigned to allow pass-through reimbursement for uncontrollable and statutory expenses - taxes, benefits, electricity, gas/propane - as such..	2 Will this presentation and the comments be shared with the group so we can build upon what has been said.	3 Thank you for the opportunity to provide comments. We look forward to working together with you!	4	5	6 .
7	8	9	10	11	12
13	14	15	16	17	18

PARKING LOT

- …..

Workgroup Meeting Schedule

Proposed Meeting Topics	Topic	Format	Timeframe	Notes and Considerations
Meeting #1 Introductions and Overview	• Introduction • Rate discussion • Rate/APM questions	Zoom	March 2023	
Meeting #2 Data Methodologies and Rate Study	Direct/Indirect & Capital costs	Zoom	April 2023	
Meeting #3 Presentation of Trend Methodologies	Trend discussion	Zoom	April 2023	
Meeting #4 Presentation of Options for VBP and Quality	VBP and Quality	Zoom	May 2023	
Meeting #5 Presentation of Risk Adjustment Options	Risk Adjustment Discussion	Zoom	May 2023	

Questions or Comments?

Please send any questions or additional feedback from today's discussion to Bryan Lumbra (Bryan.K.Lumbra@maine.gov) and Justyn Rutter (justyn.rutter@guidehouse.com).

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